A REGIONAL CENTER OF SPECIALISTS IN ALL AREAS OF EYE CARE SINCE 1955

APPOINTMENTS
FOR ALL LOCATIONS
509-456-0107

TOLL FREE

Spokane Eye Clinic

RETINA REFERRAL

Date:_____

Please complete this form AND fax or send via secure e-mail (IEOROI@spokaneeye.com) chart notes and COLOR OCT or photos. We will contact your patient directly to schedule an appointment with one of our physicians.

☐ **Next available referral (fax to 509-747-2635)** ☐ **Urgent Referral (fax to 509-482-7130)**

For the treatment of:
- ☐ Diabetic Retinal Changes
- ☐ Retinal tear/detachment ***(For Tears/Detachments also call 509-623-9760)***
- ☐ Macular pucker/hole
- ☐ Macular Degeneration
- ☐ Retinal Edema
- ☐ Vascular Occlusion
- ☐ Dislocated lens (posterior position)
- ☐ Other _____

Referring Physician: _____

Telephone: _____

PATIENT INFORMATION

(Lack of complete patient information and/or lack of exam notes could result in a delay in processing this referral) Please send color OCT or photos to IEOROI@spokaneeye.com via secure e-mail.

Patient: _____ _____ _____
First M/I Last

Date of Birth: ____ /____ / ____ Sex: ☐ Male ☐ Female

Address: _____

City/State/ZIP:_____

Patient Preferred Phone#:_____

Patient Primary Insurance: _____

NOTICE TO PATIENTS: Consult with your health plan regarding health benefit restrictions and limitations and protocol for scheduling services. Referral does not constitute an agreement of payment for services. All claims are subject to policy limitations and plan requirements. It is the patient's responsibility to consult with PCP before scheduling any procedures not authorized above.